

State Of Connecticut

SENATE
STATE CAPITOL
HARTFORD, CONNECTICUT 06106-1591

March 11, 2015

Good afternoon Sen. Gerratana, Rep. Ritter and members of the Public Health Committee. As you know, over the interim we were involved with you in a highly productive roundtable on hospitals and healthcare. As a result of information we learned from the roundtable hearings, we proposed nine bills, seven of which are in this committee and are being heard today. These bills represent subject areas that we believe should be addressed to assist our state better regulate the new landscape of hospitals and healthcare. We look forward to working on these topics with your assistance. Specifically the bills we will discuss today are:

SB 809 AN ACT CONCERNING FACILITY FEES.

SB 810 AN ACT ESTABLISHING A SPECIAL COMMISSION ON PROVIDER PRICE VARIATION AND REFORM.

SB 811 AN ACT CONCERNING PARITY IN HOSPITAL SALES OVERSIGHT.

SB 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE.

SB 813 AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY TRANSPARENCY.

SB 814 AN ACT PROMOTING ACCOUNTABLE CARE COLLABORATIVES.

SB 815 AN ACT CONCERNING HEALTH CARE POLICY AND COST CONTAINMENT.

I will also add my own comments in support of several additional bills on the agenda today.

The seemingly arbitrary manner in which hospitals charge facility fees has become a serious concern for many of our constituents. SB 809 would regulate facility fees in three ways. First it would prohibit hospitals from charging facility fees on the procedures that Medicare Payment Advisory Commission (MedPAC) has determined can be done as safely in a physician's office as in the hospital. In our proposal, we suggest banning facility fees for MedPAC group one procedures; we now believe that these fees should be banned for group one and two. Secondly, the bill would require insurers to cover these fees as medical expenses (which Medicare does), and Thirdly the bill would limit facility fees to \$100. In addition, we would like to see added to this bill a ban on facility fees for procedures coded as "evaluation and management." Taken together these elements would provide a more rational framework for these fees.

SB 810 would create a commission on provider price variation and reform. As we have discovered the playing field is not fair for independent physicians; they cannot compete with large hospitals and health systems despite evidence that care by independent physicians can be of superior quality and is often at a lower cost. Not only can hospitals and hospital owned practices charge facility fees, they are also reimbursed at a much higher rate by insurers for the same procedures that independent physicians can provide. Even if we cannot set up such an entity immediately, a good first step would be to have our state follow the Medpac recommendation for site neutral payments for Medpac's group 1 and 2 procedures. If the procedure or treatment can be done as safely in a physician's office, why should the physician not be reimbursed at the same rate as the hospital? There should not be two standards for a reasonable and customary

cost. There are a variety of methods to create site neutral payment guidelines. One promising method would be to set a cap on the price at the Medicare rate plus a percentage.¹

Clearly, there has been a movement toward consolidation in healthcare providers. Hospitals are merging with and acquiring other hospitals and thus creating large health systems. Hospitals and health systems are also purchasing physicians' practices. These larger entities make a number of claims, of which the accuracy remains to be determined. First, they claim, "the Affordable Care Act made me do it." In truth, the ACA encourages cooperation and collaboration in order to achieve higher quality and lower cost care. The ACA encourages all the physicians who provide service to a specific patient to share information. The act does not demand consolidation and the movement toward consolidation long predates the ACA's passage. Second, these entities claim that consolidation will provide lower costs; however numerous studies have shown that in fact when physicians' practices are owned by hospitals and health systems the prices increase dramatically. It is also obvious that when hospitals are allowed to consolidate in a manner that creates a virtual monopoly, prices skyrocket. These large entities also claim they will provide higher quality care but they can provide no supporting evidence.

There are certainly smaller hospitals and health systems that are embracing integrated care using affiliation and cooperation with community physicians. These hospitals and community providers tend to offer the high quality and low cost services that our state should actively support.

SB 811 would create equal oversight for all hospital consolidations. Currently the hospital conversion process is only applied when a for-profit hospital acquires or merges with a non-profit hospital. These "conversions" must have a Certificate of Need (CON) proceeding as well as a hospital conversion proceeding. Other changes in status are governed by the CON

¹ Possibly in the range of 150% of the Medicare rate.

process alone. While certain processes are relevant only to a for-profit takeover (e.g. disposition of charitable assets), we believe that there should be increased scrutiny as well when a for-profit hospital acquires or merges with a for profit hospital and when a non-profit hospital acquires or merges with a non-profit. When Essent Healthcare sold Sharon hospital, there was nowhere near the scrutiny of that transaction as there was when Essent bought Sharon hospital. This does not appear to be a rational regulatory framework. In addition, as evidenced in the Partners' case in Boston, nonprofit hospitals should also undergo vigorous scrutiny when they acquire or merge with other non-profit hospitals.

SB 812 would set up a system to assist private practice physicians with the burden of achieving interoperability in their electronic medical records (EMR) system. The expense and complexity of creating a compliant EMR system can be difficult for community providers and this is one convenience that hospitals use to lure community physicians into becoming a hospital based practice. SB 812 encourages hospitals to use the provision in the ACA that allows them to assist community physicians with these costs

In addition, after we proposed SB 812, we learned that the state of Rhode Island has a turn-key ready health information exchange system in which medical records are transferred to a single entity with no significant burden on the community physicians. This medical record is then controlled by the patient and the patient can allow his or her physicians access to the entire record. We believe that Connecticut should move toward acquiring this system.

SB 813 would increase transparency in terms of quality and cost for medical services. As crafted it would require all hospitals to become members of the leapfrog group which provides cost and quality data on an easily accessible website. Our hope is that the APCD (All Payer Claims Database) will ultimately be able to provide this information. The bill requires the health

insurance exchange to maintain cost and quality information on its website so consumers can make informed choices. There may be other entities to include for reliable evidence on cost and quality data such as National Committee for Quality Assurance (NCQA), the Joint Commission, or the Centers for Medicare and Medicaid Services (CMS). We look forward to working with you to create a reliable quality measure. The cost and quality data must be available not only to patients, but also to entities that provide insurance to employees (including employers and unions)

The Affordable Care Act provides a safe harbor from anti-trust for physicians who join accountable care organizations (ACOs). SB 814 would regulate ACOs and ensure that Connecticut's anti-trust law creates a parallel safe harbor. The legislation would also assist community physicians in creating these entities. ACOs are part of the movement in healthcare toward a value based model and away from fee for service reimbursement. ACOs integrate patient care in a manner that should improve quality while reducing costs. This model is labor intensive for primary care physicians; this legislation will offer them assistance.

SB 815 would create a Connecticut Health Policy Commission which would be modeled on the Massachusetts Health Policy Commission. The MA entity has provided invaluable information on the state of the healthcare marketplace to consumers. It sets benchmarks for medical inflation and was instrumental in the court case that struck down the Partners merger. In MA, this entity is funded by assessments on providers and insurers. This would be a worthwhile venture for our state.

There are two additional bills related to the roundtable in the insurance committee:

SB 807 - AN ACT CONCERNING FAIRNESS AND EFFICIENCY IN INSURANCE CONTRACTING which would mitigate the unequal bargaining power of large health systems

and reduce payment disparity. Among other things it requires hospitals to negotiate separately even if commonly owned, and requires insurers to include site neutral payment policies that provide equal reimbursement to all providers for common outpatient services.

SB 808 AN ACT CONCERNING SURPRISE BILLING would prevent out of network providers from billing consumers for services when the consumer had no notice of the providers out of network status.

I would also like to offer my support for SB 253 AN ACT CONCERNING PAYMENT TO AN AMBULANCE SERVICE, SB 249 AN ACT CONCERNING DISPUTES BETWEEN HOSPITALS AND INSURERS, SB 954 AN ACT CONCERNING TRANSPARENCY OF EXECUTIVE PAY IN CERTAIN HOSPITAL TRANSACTIONS, and SB 6938 AN ACT CONCERNING THE DELIVERY OF QUALITY HEALTH CARE AND MODERNIZATION OF HEALTH CARE FACILITIES.

I learned from a constituent who had been transported to the hospital by ambulance that the ambulance company attempted to collect payment directly from the patient prior to receiving a response from the patient's insurer. In my constituent's case, the ambulance company knew the patient was insured but still attempted this hyper-aggressive collection method. It is unclear whether AMR reimburses the patient if it receives payment from both the patient and the insurer. SB 253 would prohibit the ambulance company from attempting to collect from the patient until it has received a rejection from the insurer.

SB 249 would require binding arbitration to resolve disputes between hospitals and insurers. There have been several situations over the last few years in which contract disputes between hospitals and insurers put patient care at risk. Both the hospitals and the insurers have

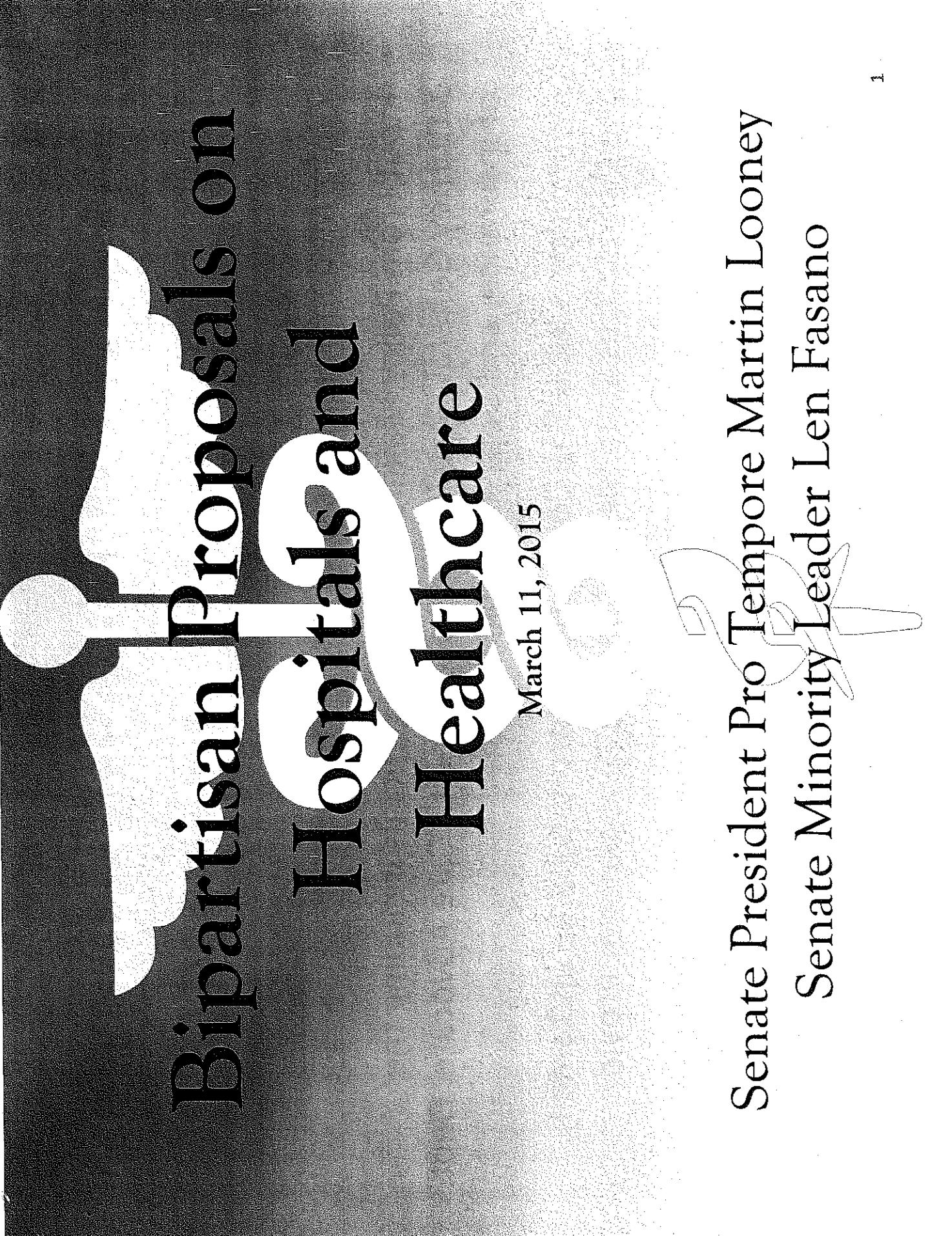
engaged in brinksmanship and put patient health at risk. This is an unacceptable situation for patients.

SB 954 would increase the transparency of hospital executive compensation during the hospital conversion process. I support this legislation and I would add to it a change in the current transparency requirements on hospital executive salaries. Under current law hospitals must disclose the salaries of their ten highest paid employees; the salaries of the ten highest paid employees of health systems should be added to this statute.

SB 6938 would require studies on some vital topics in healthcare financing including support for certain capital expenses for hospitals, and assisting hospitals by leveraging the state purchasing power to lower prescription drug costs for hospitals. I would encourage you also to look at the Massachusetts Community Hospital Acceleration, Revitalization, & Transformation (CHART) Investment Program which includes some innovative methods for supporting small community hospitals.

We have a daunting and yet invigorating task ahead of us in modernizing the regulation of our hospital and healthcare system. If we get this right, we can greatly improve the health and healthcare options for our state. The bills before you represent the beginning of that effort. The healthcare system is changing with blinding speed and we must be sure that these changes serve the interests of the residents of our state. We owe it to the citizens of our state to do this thoughtfully and without partisan divide.

Thank you for hearing these important bills.



Bipartisan Proposals on Hospitals and Healthcare

March 11, 2015

Senate President Pro Tempore Martin Looney
Senate Minority Leader Len Fasano

BIPARTISAN ROUND TABLE ON HOSPITALS AND HEALTH CARE

- 7 Informational Hearings Over 4 Months
- Input From Policy Makers And Public Officials Including the Attorney General, State Comptroller, Health Care Advocate, Dept. of Insurance, and Dept. of Public Health
- Stakeholders Including Connecticut Hospitals (large and small), the Connecticut State Medical Society, Independent Providers, and Employee Representatives
- Out of State Experts Including the Massachusetts Health Policy Commission and Rhode Island Quality Institute

KEY FINDINGS

- Rapid Change – Hospitals Are Consolidating And Purchasing Physician Practices Resulting In *Large Health Systems* With Increasing Market Power
- Lower Cost Independent Providers, Including Our Low Cost/High Quality Community Hospitals, Are Being Squeezed Out Of The Market
- Market Consolidation Is Resulting In Higher Costs For Payers and Consumers and Greater Price Disparity Between Providers
- Connecticut Lacks Critical Information Regarding Health Care Market Changes, Costs, Quality And Access
- Connecticut Is Far Behind In Providing Meaningful Price And Quality Transparency That Enables Payers And Consumers To Make Value Based Decisions
- The State's Failure To Implement A Statewide Health Information Exchange (HIE) Has Resulted in a Fragmented System That Leaves Out Many Patients and Providers



THE GROWTH OF “HEALTH SYSTEMS”

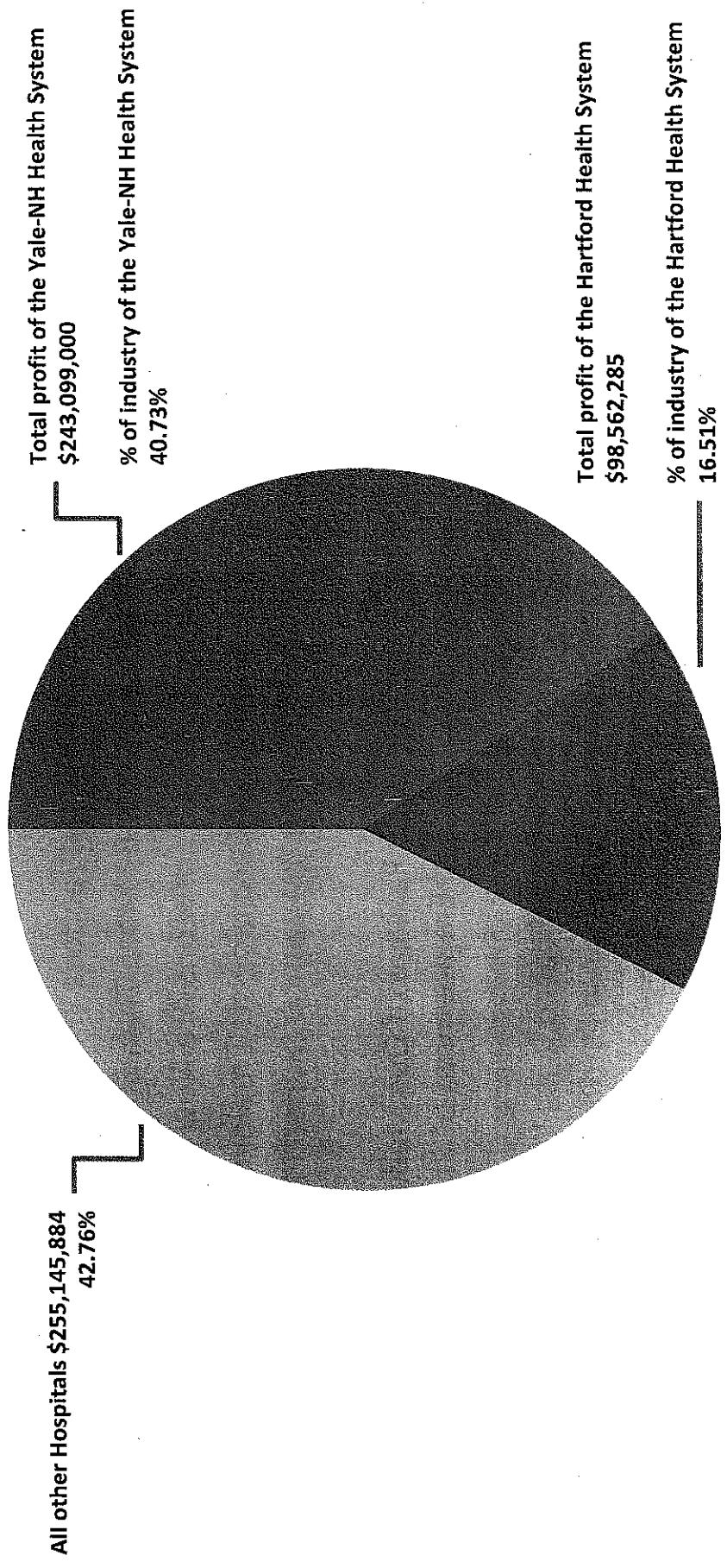
Hospital Consolidation

- Hospital Consolidations and Physician Practice Acquisitions are Occurring at a Rapid Pace Nationally and in Connecticut
- There Were Twice As Many Hospital Mergers Nationally Between 2012 And 2014 Than Previously Recorded (100 A Year Versus 50)
- Half of Our State’s Hospitals Are Part Of Large In-State Or National Health Systems And We Know More Are Looking To Be Acquired
- Two Health Systems Account For Half of All Hospital Revenue in the State
- One System Alone Receives Nearly One-Third of All Hospital Revenue and Almost 40% of All Industry Profits



“Hospital Excess Revenue Over Expenses (i.e. Profit) For 2013”

Total Industry Profit \$596,807,169



Source: OHCA - Annual Report on the Financial Status of Connecticut's Short Term Acute Care Hospitals 2013

THE GROWTH OF “HEALTH SYSTEMS”

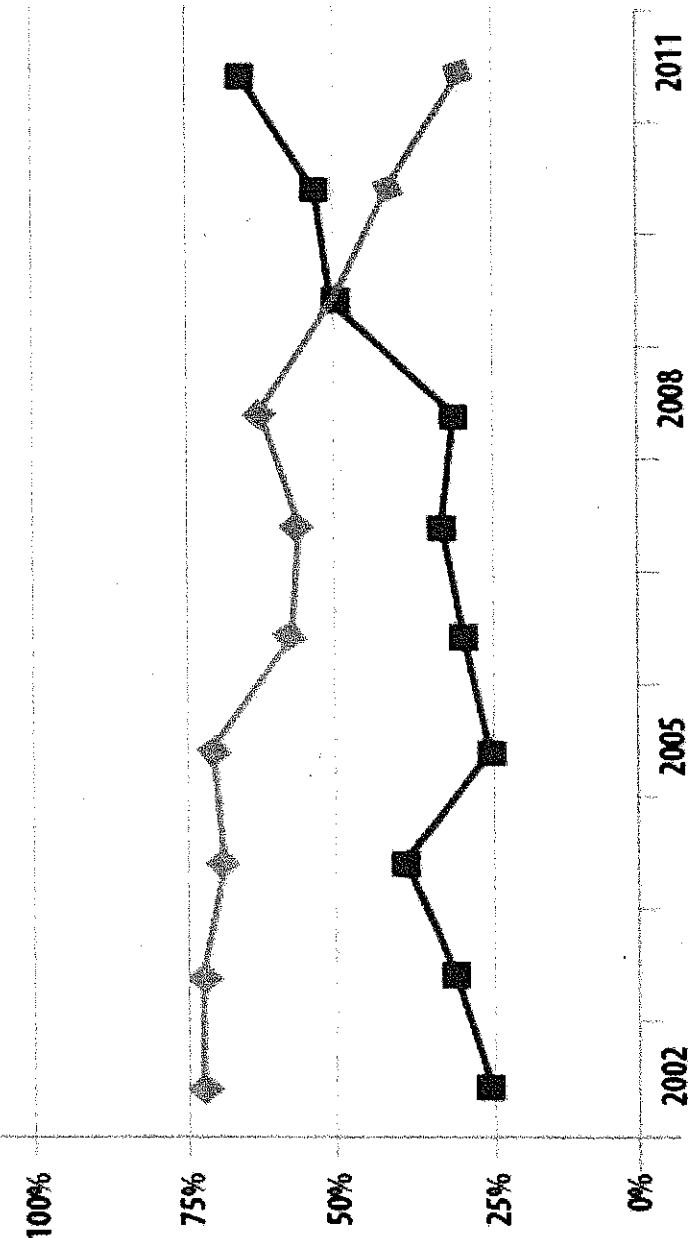
Hospitals Buying Physician Practices

- Hospitals Have Also Been Purchasing Physician Practices
 - Hospital Employment Of Physicians Grew By More Than 50% In The Last Decade
 - 60% Of Primary Care Doctors And 50% Of Surgeons Are Now “Employees”
 - Between 2007 and 2012, The Number of Cardiologists Employed By Hospitals Tripled
 - The Share of Medical Spending Attributed To Hospital Owned Physicians Increased 57% Between 2007 and 2013
- While Concrete Data Is Lacking, Since The 2009 Passage of Our Medical Foundation Law Allowing Hospitals to Employ Physicians, Hospital Employment of Physicians Appears to have Skyrocketed In Connecticut
- For Example, Northeast Medical Group, Which Is Affiliated With Yale And Formed in 2010, Now Employs Over 600 Physicians and Recently Acquired Fairfield County Based PriMed, A Group Of 120 Physicians With 31 Locations



Changing employment dynamics: Private versus hospital-owned practices, 2002-2011

Physicians in private practice —■— Physicians in hospital-owned practices



Source: Physician Compensation and Production Survey, Medical Group Management Association, 2011 Survey



CAUSES OF CONSOLIDATION AND EXPANSION

It's NOT The ACA

- Claims That The Affordable Care Act (ACA) Requires Or Even Promotes Market Consolidation Are Misplaced - Independent Providers Can Collaborate, Form Accountable Care Organizations (ACOs) And Provide Integrated Care Without Consolidating
- The Federal Trade Commission Has Warned That Efforts To Justify Health Care Mergers By Pointing To The ACA And Its Promotion Of Integrated Care and ACOs Are:
 - *"creative, but misguided ... the ACA neither requires nor encourages providers to merge or otherwise consolidate ... ACOs may be formed through contractual arrangements that are well short of a merger"*
(Julie Brill, FTC Commissioner)



CAUSES OF CONSOLIDATION AND EXPANSION

- In Rejecting A Bid By St Luke's Health Care System of Idaho To Acquire A Large Physician Practice, The FTC Argued, and the Court Agreed That:
 - *there was no persuasive evidence that a merger was needed to generate those efficiencies ... employing physicians is not necessary to achieving integrated care ... integrated care and the greater use of electronic medical records can be achieved in ways other than the acquisition of a physician practice group which created a substantial risk of higher prices. (Deborah L. Feinstein, Director Bureau of Competition, FTC)*
- In Other Words, We Can Get The Benefits of Collaboration and Integration Without the Negative Effects of Consolidation - This Is What The ACA Promotes, and This is What State Policy Should Support.



CAUSES OF CONSOLIDATION AND EXPANSION

It Is The Money

- Evidence Suggests That The Primary Motivation For Hospital Consolidations and Physician Practice Acquisitions Is Monetary - Driven By Reimbursement Policies and a Desire to Enhance Bargaining Power
- Medicare Has Historically Paid Hospitals More Than Independent Providers For The Same Service – This Payment Differential Has Two Components (1) **Facility Fees** and (2) Significantly **Higher Reimbursement Rates**
 - For Example, in Addition to Paying a Separate Hospital “Facility Fee”, Medicare Pays 70% More for an Office Consultation With A Hospital Based Provider Than An Independent Physician and Twice As Much for An Echocardiogram Or Colonoscopy
- Private Insurers Model Their Reimbursement Policies On Medicare And Also Pay Hospital Based Providers At A Higher Rate



Office vs. hospital payments

Medicare fee-for-service payments for non-emergency evaluation and management (E&M) patient visits differs between office-based physicians and hospitals. In its 2013 report, MedPAC called for "site neutral" payments for E&M visits between physician offices and hospital outpatient departments.

CPT Code	Office-based physician payment	Hospital Payment*
99201	\$41.11	\$78.18
99202	\$71.01	\$124.06
99203	\$102.95	\$174.46
99204	\$158.33	\$254.87
99205	\$197.06	\$331.33
99211	\$19.71	\$61.53
99212	\$41.45	\$100.27
99213	\$68.97	\$124.40
99214	\$102.27	\$175.48
99215	\$137.60	\$235.51

SOURCE: Centers for Medicare and Medicaid Services, 2011

*Hospital payments include payment to physician and payment to hospital.



CAUSES OF CONSOLIDATION AND EXPANSION

- Between Facility Fees And Higher Reimbursement Rates, When A Physician Practice Is Acquired By A Hospital, Costs For The Very Same Care Provided In The Same Location Go Up Dramatically
- A 2013 Report By The Medicare Payment Advisory Commission (MedPAC) Warned That These Perverse Financial Incentives Were Inducing Hospitals To Buy Up Physician Practices In Order to Generate Revenue Through Facility Fees and Higher Reimbursement Rates
- A St. Luke's Hospital Board Member Perhaps Said It Best In An Internal Document Discovered By The FTC -

“Employing physicians is not achieving better cost, it’s achieving better profit.”



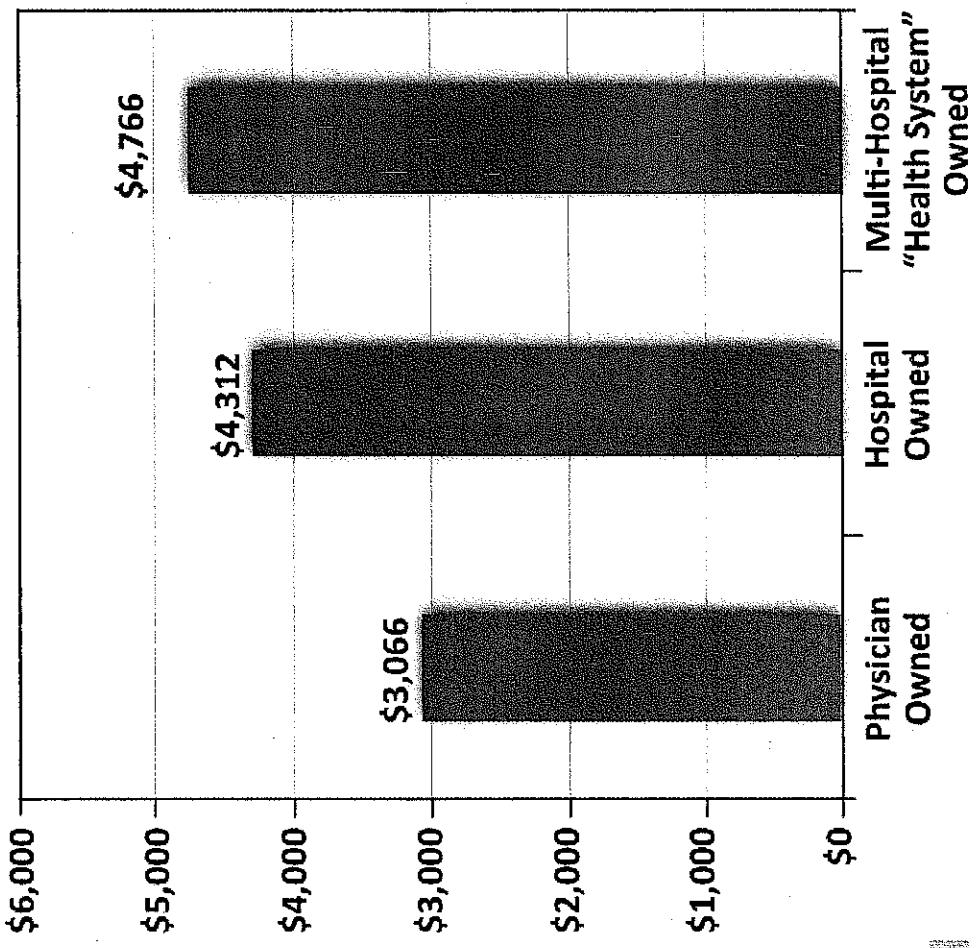
HOSPITAL CONSOLIDATION AND EXPANSION LEADS TO HIGHER COSTS

- A 2012 Robert Wood Johnson Report Found that (1) Hospital Consolidation Results In Higher Prices With Increases Often Exceeding 20% and (2) Hospital Physician Practice Acquisitions Have Not Led To Improved Quality Or Reduced Costs
- A California Study Published Last Year In JAMA Found That Per Patient Expenditures By Hospital Employed Physicians Were Almost 20% Greater Than Independent Physicians
- A Recent Study By The Institute For Policy Research At Northwestern University Found:
 - Hospital Employment Of Physicians Was Associated With **Significant Price Increases**, More Than 30% for Some Specialties Such As Cardiology
 - When The Acquiring Hospital Has A Virtual Monopoly In Its Local Market, Price Increases Are An Additional **20% Higher**
 - Facility Fees Represent One Quarter of The Overall Increase In Prices
 - There Was No Evidence That Physician Practice Acquisitions Led To Reduced Spending
 - The Most Efficient Practice Model Appeared To Be A **Small Group of 7-10 Physicians**



Per Patient Expenditures

From: "Total Expenditures Per Patient In Hospital Owned and Physician-Owned Physician Organizations in California", JAMA 2014

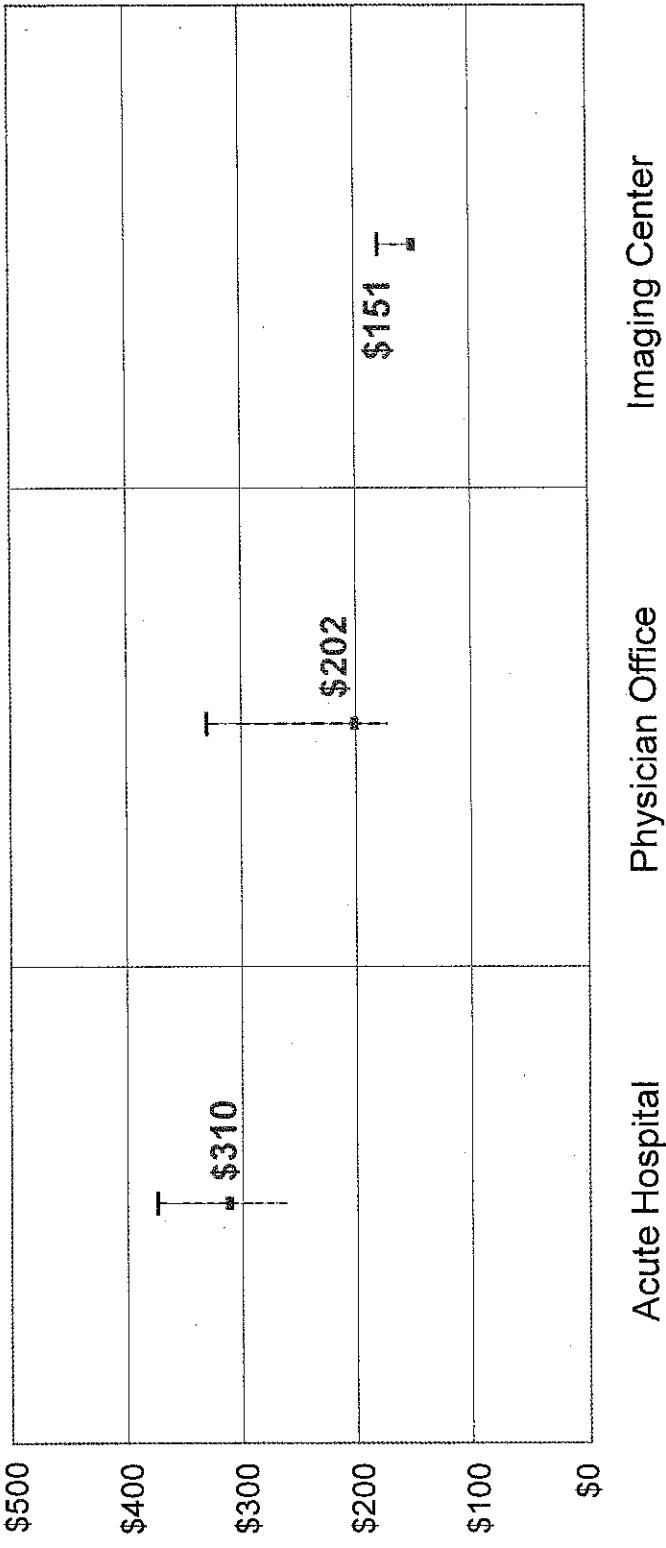


HOSPITAL CONSOLIDATION AND EXPANSION LEADS TO HIGHER COSTS

- As MedPAC and the Mass. Health Policy Commission Have Found:
 - Hospital Physician Practice Acquisitions Have a Compounding Effect on Costs Because They Implicate All of the Major Contributors to Rising Costs – *Utilization, Unit Cost and Provider Mix*
 - More Providers Bill At The Higher Hospital Rate and They Refer More Patients For More Services to Fellow Hospital Employed Physicians
- By Expanding Their Physician Practice Network Hospitals Guarantee Themselves a Steady Supply of Referrals and Expand the Sites of Service at Which They Can Charge Facility Fees and Higher Rates.



Price Variation for Screening Mammography by Provider Type, 2012



25th Percentile Median Price 75th Percentile
Massachusetts Center for Health Information and Analysis



CONSUMERS ARE PAYING THE PRICE

- While Connecticut Lacks System Wide Data Regarding the Impact of Hospital Consolidation and Expansion, Anecdotal Evidence Suggests The Costs Are Staggering
- The Health Care Advocate Testified That:
 - A consumer undergoing chemotherapy saw the charge for a routine injection go from **\$2,500 to almost \$12,000** after the practice was purchased by a hospital, with a corresponding increase in his out of pocket costs.
 - Another Consumer Received A Bill From A Hospital Of **Over \$5,000** For An Echocardiogram When The Average Cost For Such Procedure Is Just \$1,100
- An Independent Radiologist Testified That:
 - The Hospital Rates For Routine Diagnostic Imaging Tests Are Often **2 to 3 Times Higher** Than At An Independent Facility
 - When Norwalk Hospital Acquired The Norwalk Radiology Center, A CT Scan That Might Have Previously Cost \$550 Suddenly Cost Over \$3,000



Adjusted Chemotherapy Episode Costs, by Length of Episode

Length of episode in months	Number of episodes	Average episode cost	HOPD-managed episodes	Number of episodes	Average episode cost	Percent difference
1	4,601	\$10,764	1,784		\$13,828	28.5%
2	3,679	\$17,431	1,240		\$23,917	37.2%
3	2,502	\$26,893	1,091		\$32,541	21.0%
4	2,518	\$33,192	859		\$42,628	28.4%
5	1,601	\$39,220	481		\$53,538	36.5%
6	1,151	\$49,062	332		\$61,661	25.7%
7	1,091	\$39,888	268		\$55,216	38.4%
8	635	\$47,709	165		\$74,066	55.2%
9	734	\$42,838	127		\$75,645	76.6%
10	445	\$48,683	105		\$67,003	37.6%
11	302	\$67,068	69		\$86,938	29.6%
12	303	\$66,826	85		\$102,395	53.2%

Source: Avalere Health analysis of NAMCP member data

Cost estimates adjusted for age, sex, and prior history of cancer

Costs include all care received by patient during chemotherapy episode, including some care unrelated to the provision of chemotherapy



CONSUMERS ARE PAYING THE PRICE

- Our State Comptroller, As Administrator For The State's \$1.4 Billion a Year Employee and Retiree Health Plan, Warned That:
 - “*provider consolidation with hospitals may result in increased health care prices and total costs. The impact is measurable both in hospital prices and in per-patient expenditures of hospital-owned physician practices.*”
- MedPAC Has Warned That The Migration Of Previously Independent Practices To Hospitals Is Costing Medicare Billions Of Dollars For The Same Care
 - MedPAC has Recommended Eliminating Medicare Reimbursement For Facility Fees And Equalizing Reimbursement Rates For Those Procedure That Can Be Safely Performed In Non-Hospital Outpatient Settings – This Proposal Could Save Medicare **\$30 Billion Over 10 Years – More Than Raising The Eligibility Age to 67!**
- Thus, Facility Fees and Increased Hospital Based Reimbursement Rates Are Putting Strain On Government Funded Programs, Employers and Consumers



THE WAY FORWARD

- Whatever One's Position Is On The ACA, We Cannot Let Its Promise of Expanded Coverage, Improved Outcomes and Increased Efficiency Be Squandered
- To Ensure That Consumers Realize the Benefits of These Policies We Must Mitigate The Anticompetitive Effects of Market Consolidation Through:
 - Greater Market Scrutiny and Oversight
 - Policies That Promote Collaboration Over Consolidation and Support Our Low Cost/High Quality Providers and Hospitals
 - Increased Price and Quality Transparency To Empower Payers and Consumers to Make Value Based Decisions About Their Care
 - Robust Electronic Health Information Systems That Allow Health Records To Follow The Patient And Promote Efficient Integrated Care Regardless of Provider Setting



S.B. 815 AN ACT CONCERNING HEALTH CARE POLICY AND COST CONTAINMENT.

- Establish a *Connecticut Health Policy Commission* To:
 1. monitor and report on health care cost, delivery and payment trends,
 2. recommend policy changes to reduce health care costs and improve quality,
 3. establish benchmarks for health care cost growth,
 4. identify providers that exceed the benchmarks and work with them to implement a performance improvement plan,
 5. analyze provider mergers and acquisitions , identify those likely to significantly impact health care competition or costs, and provide a cost and market impact analysis to the Attorney General and the Office of Health Care Access.
- Based on Mass Health Policy Commission - A Single Independent State Agency Responsible for Monitoring and Reporting on Health Care Costs and Market Trends



S.B. 815 AN ACT CONCERNING HEALTH CARE POLICY AND COST CONTAINMENT.

- The Mass Health Policy Commission Played An Instrumental Role In Analyzing The Potential Impact of a Hospital Merger Saving Massachusetts Consumers Millions:
- Blocking a Proposal by Partners HealthCare, a Large Non-Profit Health System, to Buy Three Community Hospitals in Eastern Mass, the Court Relied Upon the Commission's Analysis Showing:
 - Massachusetts spends more on health care than any other state
 - 21% to 39% of Massachusetts health care spending is “wasteful”
 - Massachusetts is dominated by a few large health systems that use their market leverage to increase prices
 - Partners' Hospitals and Physicians Were - “*consistently the highest priced*” and their “*high costs do not translate into higher quality care.*”
 - Partner's Purchase of Just These Three Hospitals Would Increase Health Care Costs by \$38 to **\$49 Million a Year.**
- Connecticut Lacks this Kind of Detailed Economic Data and Analysis. Massive Changes Have Occurred in our Health Care Market with Little Analysis or Understanding of the Impact on the State, Our Economy or Individual Consumers

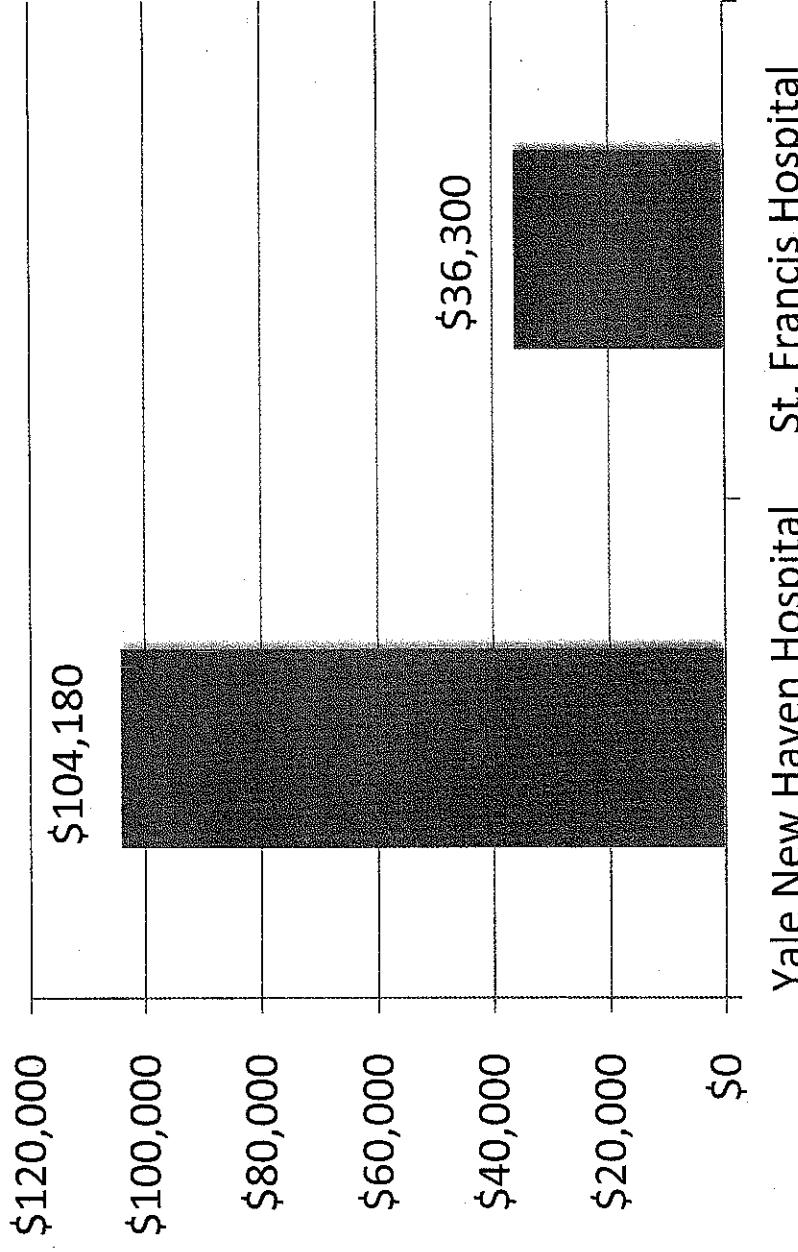


S.B. 810 AN ACT ESTABLISHING A SPECIAL COMMISSION ON PROVIDER PRICE VARIATION AND REFORM.

- Establish a Special Commission to Study Provider Price Variation - (i.e. the difference in the prices charged by various providers for the same services, such as hospitals vs. independent providers, large versus small hospitals, etc.)
 - Commission to include Attorney General, Health Care Advocate, Insurance Commissioner and Representatives of Payers, Providers and Patients
 - Report in 2016 on Extent of Price Variation, Causes and Recommendations to Reduce Variations that are not Justified by Actual Differences in Costs or Quality.
- We Know Price Variation Exists and Can be Dramatic. However, We Lack Connecticut Specific Statewide Data on the Extent of Such Variation and its Impact on Total Medical Costs as well as Consumers' Out of Pocket Costs.
- A Massachusetts' study found significant unjustified price variation among providers with large hospitals and hospital systems charging significantly more than smaller hospitals and independent providers – **often a 3 to 7 times factor**. It also found that simply narrowing the range of variation to within the current 20th to 80th percentile would save payers, including the state, **over \$250 million a year**.



Cost of Implanting a Permanent Cardiac Pacemaker



Source: "Hospital Mergers Raise Concerns Over Patient Costs", Conn. Health Investigative Team, March 23, 2014.



P.B. 813 AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY TRANSPARENCY.

- Conn Receives an “F” for Price and Quality Transparency in National Surveys
- To Promote Low Cost/High Quality Care, Consumers and Payers Must Have Timely, Accurate and Understandable Price and Quality Information
- S.B 813 Would Move Us Closer To This Goal By:
 - 1) Developing a *consumer health information website* that allows consumers to compare cost and quality data across all payers and providers and enables them to make informed choices regarding their care;
 - 2) Requiring providers to give consumers *timely information regarding the price* of scheduled procedures and services and to disclose business relationships with any providers to which they are referring a patient;
 - 3) Requiring insurers to establish *toll free numbers and websites* allowing insureds to obtain real time information regarding charges for services and the amount the insured will be responsible to pay including any facility fee, copay, deductible, coinsurance or other out of pocket cost;
 - 4) Require hospitals to participate in a *nationally recognized cost and quality rating system* and provide consumers with information regarding their performance and ratings.



P.B. S13 AN ACT CONCERNING HEALTH CARE PRICE, COST AND QUALITY TRANSPARENCY.

- Price Transparency is a Powerful Tool for Cost Containment - A Recent Report by the West Health Policy Center Found that Providing Patients, Physicians, Employers and Policy Makers with Price Information Could Save **\$100 Billion Over 10 Years**, Including **\$15 to \$20 Billion in Out of Pocket Costs** for Consumers;
- New Hampshire Found that Simply Publicizing and Exposing the Price Disparity Among Providers had a **Significant Impact** on the Market - **Price Variation Decreased Substantially** as Higher Priced Providers Reduced their Rates to Meet the Demands of Consumers, Payers and Policy Makers;



S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- The Seamless Exchange of Patient Health Information Across All Provider Settings is Essential to Achieve the Triple Aim of Improving the Quality of Patient Care, Improving Population Health, and Containing Costs
- ***Health Records Must Follow The Patient.*** The State Must Affirm as a Matter of Policy That Health Records Belong to the Patient, Not the Provider. Patient Medical Records Are Not Proprietary and Should Not be Used for Competitive Advantage.
- Without the Sharing of Patient Information, the Promise of Electronic Health Records to Improve Accurate and Timely Diagnosis, Eliminate Duplicative Testing, Reduce Medical Errors and Improve the Overall Efficiency of Health Care Delivery Cannot be Achieved



S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- Recognizing the Inconsistent Implementation of HIE at the State Level, the Federal Office of the National Coordinator for Health IT Recently Issued a 10 Year Health IT Roadmap that Recommends the Following:
 - A **Public-Private Partnership** and Governance Framework
 - A Focus on Systems that **Maximize Information Sharing** with the Least Amount of Effort and Cost
 - **Sustainable Funding** Mechanisms
 - Increased **Public and Private Incentives** for Providers to Implement Interoperable Electronic Health Records Systems
- SB 812 Seeks to Put Connecticut on this Road Map By:
 - Committing the State to the Implementation of a Statewide HIE
 - Creating a Sustainable Funding Mechanism to Support the Statewide HIE that Includes Public and Private Support
 - Providing Support and Incentives for Providers to Adopt Interoperable Electronic Health Records Systems that can Share Information Through the HIE



S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- Commitments From Stakeholders :
 - Everyone- the State, Employers, Commercial Payers, Providers and Patients – Stands to Benefit From a Fully Functioning State HIE. ***Everyone Should Contribute to its Success.***
 - SB 812 Does This by Requiring (1) Hospitals to Ensure the Interoperability of their Own Systems and to Support Community Providers in Adopting Electronic Health Records Systems, (2) Payers to Contribute to Funding the State HIE and to Provide Enhanced Reimbursement to Providers with Certified Electronic Health Records Systems, and (3) the State to Provide Seed Funding for the HIE as well as Loans, Grants and Tax credits for Providers.
 - These Joint Investments and Contributions are Critical to the Long Term Success of this Effort and Have Been Shown to Work in Other States.



S.B. 812 AN ACT CONCERNING ELECTRONIC HEALTH RECORDS AND HEALTH INFORMATION EXCHANGE

- Numerous Studies Have Shown the Value of HIE in Terms of Patient Care, Quality and Costs;
 - A 2014 Study by Weill Cornell Medical College Showed a **30% Reduction in Hospital Admissions** Through HIE Use
 - Research from the American College of Emergency Physicians Showed that HIE use Resulted in Average **Savings of \$2,000 Per Patient** by Reducing Tests and Hospital Admissions. ER Physicians also Reported that Quality of Patient Care Improved.
 - Rhode Island, Which has a Successfully Operating Statewide HIE, Found a Statistically Significant Reduction in Hospital Readmissions Resulting in **Savings of \$24 Million** in 2013



S.B. 809 AN ACT CONCERNING FACILITY FEES

- According to a 2014 Conn Attorney General Report, **22 of 29 Conn hospitals charge facility fees** and they can range from **\$100 to more than \$1,000** - Although the State Health Care Advocate Reports of Facility Fees as High as \$5,000
- A federal study found that, by 2021, facility fees for routine doctor visits and cardiac imaging tests alone will **cost Medicare an extra \$2.3 billion** and patients an extra \$590 million in out-of-pocket expenses each year.
- MedPAC has recommended **eliminating Medicare reimbursement for facility fees** related to outpatient services that have historically been provided in physician offices or non-hospital outpatient settings and can safely be provided in such settings.
- SB 809 Would Crack Down on the Inappropriate Use of Facility Fees By:
 - 1) Prohibiting facility fees for procedures in group 1 of the Medicare ambulatory payment classifications (i.e. those MedPAC has determined can be safely performed in an outpatient setting)
 - 2) Capping all other facility fees at \$100
 - 3) Requiring insurance coverage of such fees



S.B. 814 AN ACT PROMOTING ACCOUNTABLE CARE COLLABORATIVES.

- Accountable Care Organizations (ACOs) are a Voluntary Network of Providers (Hospitals, Primary Care Physicians, Specialists, etc.) Who Agree to Coordinate Care for a Group of Patients
- The Center for Medicare and Medicaid Services (CMS) Certifies ACOs to Participate in the Medicare Shared Savings Program. Providers Manage and Coordinate Care for Medicare Patients and are Eligible to Share in any Savings Generated.
- Because Federal Antitrust Laws Generally Prohibit Independent Market Participants Joining Together to Negotiate Prices, the Federal Government has Carved out an Antitrust “Safe Harbor” for Providers Participating in a Medicare ACO that Allows Those Providers to Jointly Negotiate Payment Terms.
- While ACOs are Being Developed in the Private Market Outside of Medicare, There is No State Regulatory Framework for Such Entities. A Number of States, Including New York, Are Developing A Certification Process for State ACO Like Entities and Granting State Certified ACOs the same Antitrust Safe Harbor.



S.B. 814 AN ACT PROMOTING ACCOUNTABLE CARE COLLABORATIVES.

SB 814 Would Promote the Development of State Accountable Care Collaboratives By:

1. Providing **state certification for Accountable Care Collaboratives (ACC)** - a group of clinically integrated health care providers that work together to provide, manage and coordinate care for a defined group of patients and share accountability for the quality and cost of such care;
2. Giving providers in a state certified ACC a “**safe harbor**” under state antitrust laws allowing them to negotiate rates and payment terms.
 - The Goal is to (1) Promote the Development of State ACO like Models of Care, which Promise to Improve Patient Outcomes and Reduce Costs through Better Coordination and Integration of Care, and (2) Encourage the Participation of Small Independent Providers, Who are Often the Low Cost/High Quality Providers, in these Care Models.



S.B. 811 AN ACT CONCERNING PARITY IN HOSPITAL SALES OVERSIGHT

- Apply Our State's Hospital Conversion Process to Sales Between Non-profit Entities
- As the Partners Healthcare Case in Massachusetts Demonstrates, Non-profit Health Systems Can Engage in Anticompetitive Behavior and the Expansion of Non-profit Health Systems Can Have a Significant Impact on Health Care Costs for the State and for Consumers
- Regardless of the Tax Status of the Purchaser, There Needs to be a Thorough and Thoughtful Review of Any Hospital Sale to Determine its Impact on Health Care Costs and Access to Care
- S.B. 811 Would Also Require OHCA to Consider the Potential Negative Impact on the Community and Access to Care if a Proposed Sale is not Approved and Weigh these Potential Negative Effects Against the Benefits of the Conditions it Seeks to Impose.



OTHER PROPOSALS – SUPPORTING COMMUNITY HOSPITALS AND PROVIDERS

While Large Well Capitalized Health Systems Are Thriving, Many of Our Smaller Community Hospitals and Providers Struggle. They Cannot Afford to Buy Physician Practices Nor do they Have the Bargaining Power to Negotiate Higher Rates. Yet They Often Provide the Kind of Value Based Care the ACA Seeks to Promote.

To Support These Hospitals and Providers We Should Consider:

1. *Maintain Funding For Small Low Cost/High Quality Hospital Pool*

State hospitals receive hundreds of millions a year in state and federal reimbursement through the Medicare and Medicaid programs. To promote the efficient delivery of high quality care in low cost settings, a portion of that state support should be set aside to support our small community hospitals who provide such care. Despite difficult state budget constraints, every effort should be made to maintain the \$15 million set aside to support our small low cost hospitals.

2. *A Community Hospital Investment and Transformation Program*

Establish a Competitive Process For State Loans and Assistance With an Emphasis on Proposals that Promote Efficient Integrated Care Delivery, Coordination of Resources, the Ability to Participate in ACOs and the Adoption of Electronic Health Records. (Based on Massachusetts CHART Program)



OTHER PROPOSALS – SUPPORTING COMMUNITY HOSPITALS AND PROVIDERS

3. State Assisted Purchasing

State Statutes Allow DAS to Enter into Cooperative Purchasing Agreements With Nonprofit Organizations and Allow Certain Government Funded Entities to Purchase Through DAS. However, the State Has No Specific Purchasing Program for Community Hospitals or Providers. We Should Consider Implementing Such a Program to Assist Community Hospitals and Providers in Achieving Savings in Their Purchasing of Supplies, Services and Equipment.

4. A Model ACO Program

Establish a Model ACO Program That Gives Preference to State Certified ACOs that Meet Certain Metrics, Such as the Inclusion of Low Cost/High Quality Hospitals and Independent Providers, and Support Such ACOs Through the State Employee and Retiree Health Plan, Medicaid and Other State Administered Programs.



OTHER PROPOSALS – SUPPORTING COMMUNITY HOSPITALS AND PROVIDERS

5. Community Health Teams

Support the Development of Community Health Teams to Provide Practice Management and Care Coordination Services to Small Independent Providers to Help Facilitate Their Participation in ACOs and Modern Care and Payment Models. Small Practices, While Often High Quality and Low Cost, Do Not Have the Internal Staffing or Financial Resources to Support the Infrastructure Required to Participate in ACOs and Integrated Care Models. Yet, They Are Often the Providers who Can have the Greatest Impact on Patient Health, Utilization and Costs.



OTHER PENDING LEGISLATION

In addition to these bills, we have two bills pending in the Insurance Committee:

P.B. 807 - AN ACT CONCERNING FAIRNESS AND EFFICIENCY IN INSURANCE CONTRACTING is intended to mitigate the unequal bargaining power of large health systems and reduce payment disparity by, among other things, requiring (1) hospitals to negotiate separately even if commonly owned, and (2) insurers to include site neutral payment policies that provide equal reimbursement to all providers for common outpatient services.

P.B. 808 AN ACT CONCERNING SURPRISE BILLING is intended to prevent out of network providers from billing consumers for services when the consumer had no notice of the providers out of network status.



CONCLUSION

Together all of these bills are designed to:

- 1) protect consumers from unjustified price increases and facility fees;
- 2) empower consumers through greater price transparency,
- 3) mitigate the anticompetitive effects of hospital and provider consolidation and reduce price disparity among providers,
- 4) increase the state's oversight of the health care market,
- 5) support independent low cost/high quality providers, and
- 6) promote efficient patient centered care through the adoption of electronic health records and a state health information exchange.

We look forward to working with the committee and stakeholders to further develop these proposals. The status quo of a system based on secrecy, market power and resource control cannot stand. The costs of such a system threaten to overwhelm the progress made in expanding coverage and are unsustainable.



Source Material

- "Monopolizing medicine: Why hospital consolidation may increase healthcare costs" Medical Economics, Feb. 24, 2014
- "When Hospitals Buy Doctor's Offices, and Patient Fees Soar", New York Times, Feb 6, 2015
- "The Effect of Hospital Acquisitions of Physician Practices on Prices and Spending", Institute for Policy Research, Northwestern University, Feb. 2015.
- "A Common Sense Medicare Solution: Site-Neutral Payment Reform", Barry Brooks, Roll Call, Feb. 25, 2015
- "Hospital Mergers Raise Concerns Over Patient Costs", Conn. Health Investigative Team, March 23, 2014.
- "Hospital Ownership of Physician Practices Is Associated With Higher Prices and Spending," Health Affairs, May 2014.
- "Health Information Exchange Saves \$1 Million in Emergency Care Costs for Medicare." American College of Emergency Physicians, Oct. 14, 2013
- "HIE Use Results in Fewer Hospitalizations, Cost Savings," FierceHealth, March 13, 2014
- Report to Congress: Medicare and the Health Care Delivery System, "Medicare Payment Differences Across Ambulatory Settings"(Chap. 2), Medicare Payment Advisory Commission*, June 2013
- The Impact of Hospital Consolidation- Update*, Robert Wood Johnson Foundation, The Synthesis Project, June 2012.
- Total Hospital Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California*, Journal of the American Medical Association, Oct. 2014.
- Total Cost of Cancer Care by Site of Service: Physician Office vs Outpatient Hospital*, Avalere Health, March 2012.
- Massachusetts Health Care Cost Trends, Price Variation in Health Care Services*, Division of Health Care Finance and Policy, June 2011.
- Report to Bipartisan Round Table on Hospitals and Health Care*, Rhode Island Quality Institute (RIQI), Feb. 26, 2015.
- Report Card on State Transparency Laws*, Catalyst for Payment Reform, March 25, 2014
- "COMPETITION IN HEALTH CARE MARKETS," Keynote Address by Julie Brill
Commissioner, Federal Trade Commission
- "Antitrust Enforcement in Health Care: Proscription, not Prescription,"
Fifth National Accountable Care Organization Summit – Washington, DC, June 19, 2014
- Deborah L. Feinstein, Director, Bureau of Competition, Federal Trade Commission
- Massachusetts v. Partners Healthcare System, Inc., SUCV2014-02033-BLS2, Mass. Supp. Ct., Jan. 29, 2015.

